

Beveridge & Bismarck Healthcare System Model and Indonesia's Condition Compared to Other ASEAN Countries

Sahasika Prayata

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Agenda

Healthcare System - Beveridge & Bismarck Model

Indonesia's Healthcare System

Healthcare Spending & Funding Resource

Healthcare System - Beveridge & Bismarck Model

Beveridge & Bismarck Model Introduction

Beveridge



Through general taxation



Funding to providers
(mainly public)



Citizen

Revenue pooling received from general taxation (income tax, corporate tax, VAT, tariff, etc). Central taxation may lower the administrative costs

Government

Government acts as a single-payer. Government also sets health policies, decide essential services, and enforces quality standards to ensure consistency. Funds may be distributed centrally or regionally

Healthcare Providers

Healthcare providers are often government-owned but may also include private providers with government schemes (need additional insurance or copayment).

Bismarck



Through payroll contribution



Funding to providers



Employers & Employee

Both employers and employees are required to contribute to healthcare financing through payroll deductions or premiums, often sets as percentage of salary

Private Organization / Sickness Fund

Utilize multi-payer system with private organizations compete to attract members by offering better services or broader coverage. Employers and employee usually have a freedom to choose their sickness fund

Healthcare Providers

Can be both public or private and are reimbursed by "sickness fund". Those private organizations negotiates with the hospital for the rates. However, advanced treatment may need the individuals to have additional insurance or co-payment.

Beveridge Model



Sir William Beveridge (1879—1963)
“Health as a human right”

The Beveridge model originated in the United Kingdom and emerged in the 1940s. This system is based on universal access to healthcare and all medical services are managed directly by the Government. Universal healthcare is funded through general taxation

Principles

- Universality → social security that seek to cover all social risks and to encompass the entire population
- Unity → uniformity of contributions, which would vary only with the scope of protection guaranteed
- Integration → technical integration and social integration

Strengths

- Social justice and equity (healthcare as a right, not a privilege)
- Financial security (prevent medical debt)
- Standardized quality and access (ensuring access to essential services)

Challenges & considerations:

- Long waiting lists
- Underfunding may put pressure on the quality of care
- Rising healthcare costs (as people get older) → limits on services or higher taxes
- Limited choice and competition → raising concerns about innovation and responsiveness to the patients

“A government-run national health service (Beveridge model) can provide care for all at a reasonable cost but cannot avoid the dangers of poor quality” - Michael Cichon and Charles Normand

Bismarck Model



Otto van Bismarck (1815—1898)
"Mandatory health insurance"

Born in Germany in 1833, the Bismarck model is a health system that is based on the fact that citizens enjoy health care through private organizations. The Bismarckian model established state social insurance with prepayment by workers and their employers. It utilized Sick Funds (Krankenkassen) as insurers to provide payment to the physician, hospital, or other provider.

Principles

- Solidarity → shared responsibility and risk across society through mandatory health insurance
- Self-governance → gives healthcare institutions and insurance providers the ability to govern themselves within the system
- Competition → to improve quality and efficiency within the system, encourage innovations

Strengths, according to Cichon & Normand:

- Broad coverage
- Improved access to care, including shorter waiting times
- Financial stability → promoting system sustainability and reducing dependence on government budgets
- Competition and innovation → enhancing the overall healthcare services

Challenges & considerations:

- High labour cost
- Administrative complexity
- Social inequalities → Income disparities can influence access to specialized care or treatment options

"An insurance-based system (Bismarck model) can achieve high quality but cannot ensure care for all at an affordable cost" - Michael Cichon and Charles Normand

There are 4 major types of healthcare system

Bismarck Model

Also referred to as a “social health insurance model. This model of healthcare is funded by employers and employees through payroll deductions as their primary source for healthcare revenues

In practice it tends to only be available to the working population, and so does not provide universal health coverage

Beveridge Model

Often referred to as the “universal healthcare” model. National Health Service systems rely primarily on general taxation for health care revenues and control provision at the central government level.

In this model, healthcare settings can be owned by the government or privately with government funding, however the majority of healthcare professionals are government employees.

National Health Insurance Model

Combines elements of both the Beveridge and Bismarck models, with a government-run national health insurance that is publicly funded through taxes, and services are delivered by both private and government-run providers

Out-of-Pocket / Uninsured Model

The majority of countries, particularly developing countries, have healthcare systems where individuals are required to pay for their own care directly without an insurance system. This type of model is market-driven and predominantly seen in developing countries, isolated communities, and uninsured populations.

Out-of-pocket (OOP) payment is considered as the most inequitable and inefficient method for health care financing, often leaving vulnerable patients without access to care and further impoverished

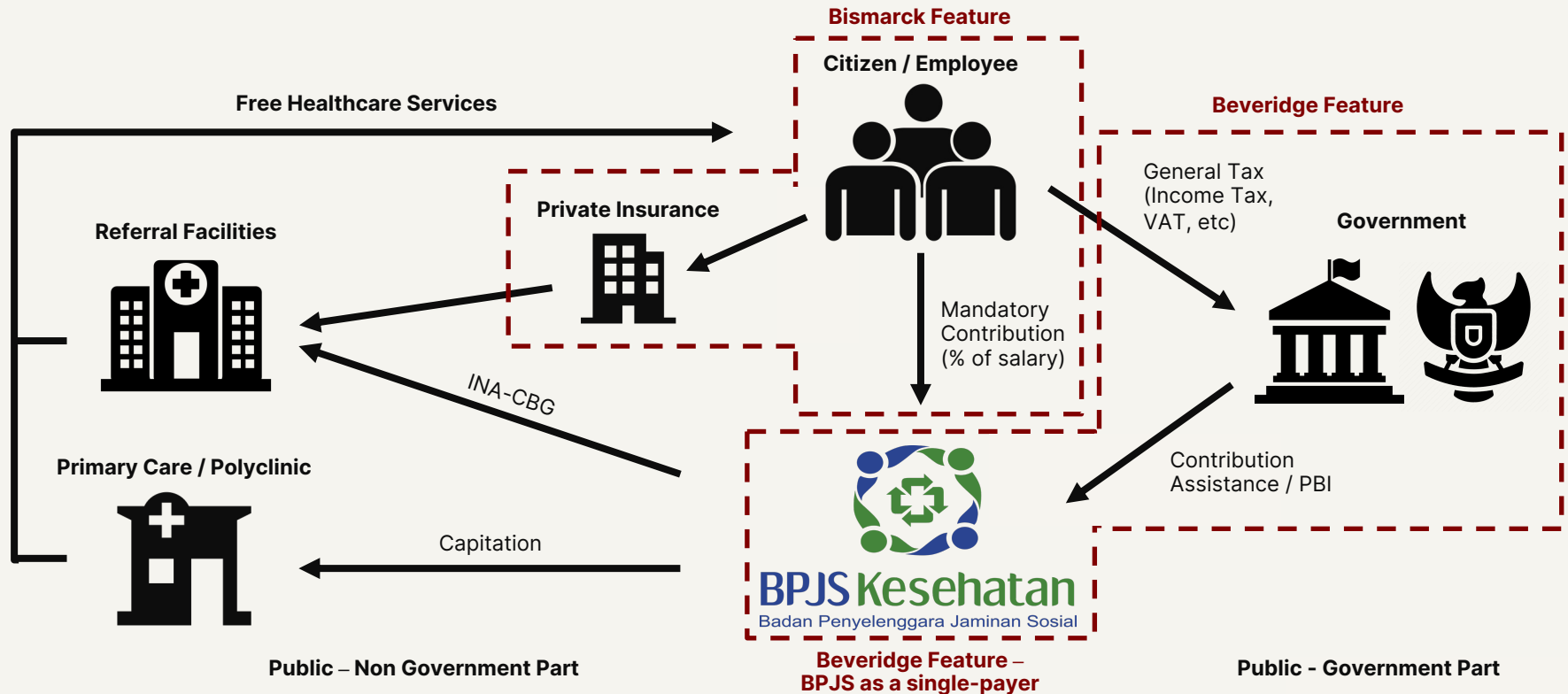
Economists evaluate the effectiveness of a healthcare system on three criteria: Access, Cost, and Quality

“The best chance of achieving a reliable financial base for health services is to use a combination of both these approach”

“No model is suited to all nation circumstances”

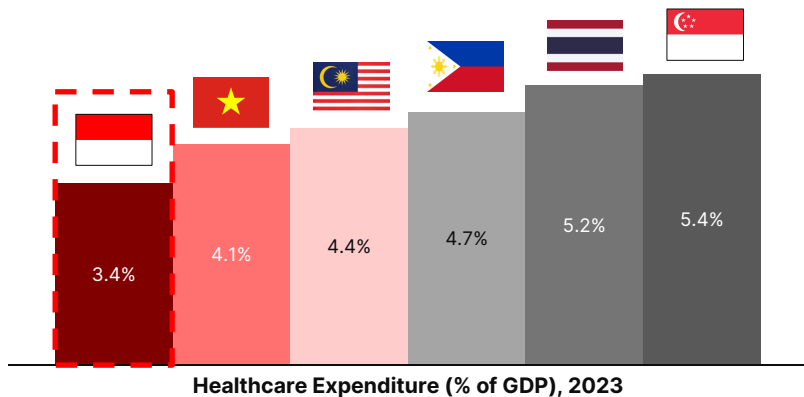
Indonesia's Healthcare System

Indonesia's healthcare system adopts a National Health Insurance model, combining both Beveridge and Bismarck features. However, with government funding directed to BPJS, which acts as a single-payer entity, the system leans more toward the Beveridge model.



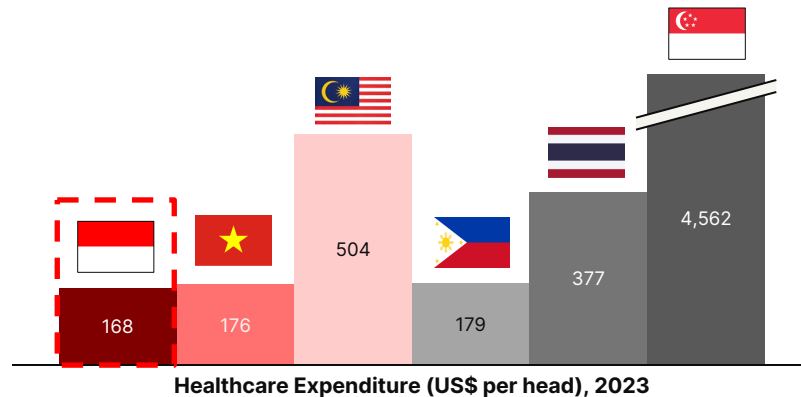
Healthcare Spending & Funding Resource

The two measures commonly used to compare levels of healthcare spending across countries are healthcare spending as a percentage of the Gross Domestic Product (GDP) and healthcare spending per capita



Despite being the largest economy in Southeast Asia, Indonesia continues to lag in healthcare expenditure as a percentage of GDP, with a rate of 3.4%.

This indicates Indonesia's relatively lower commitment to healthcare funding, impacting its ability to enhance healthcare services and infrastructure compared to its regional peers.

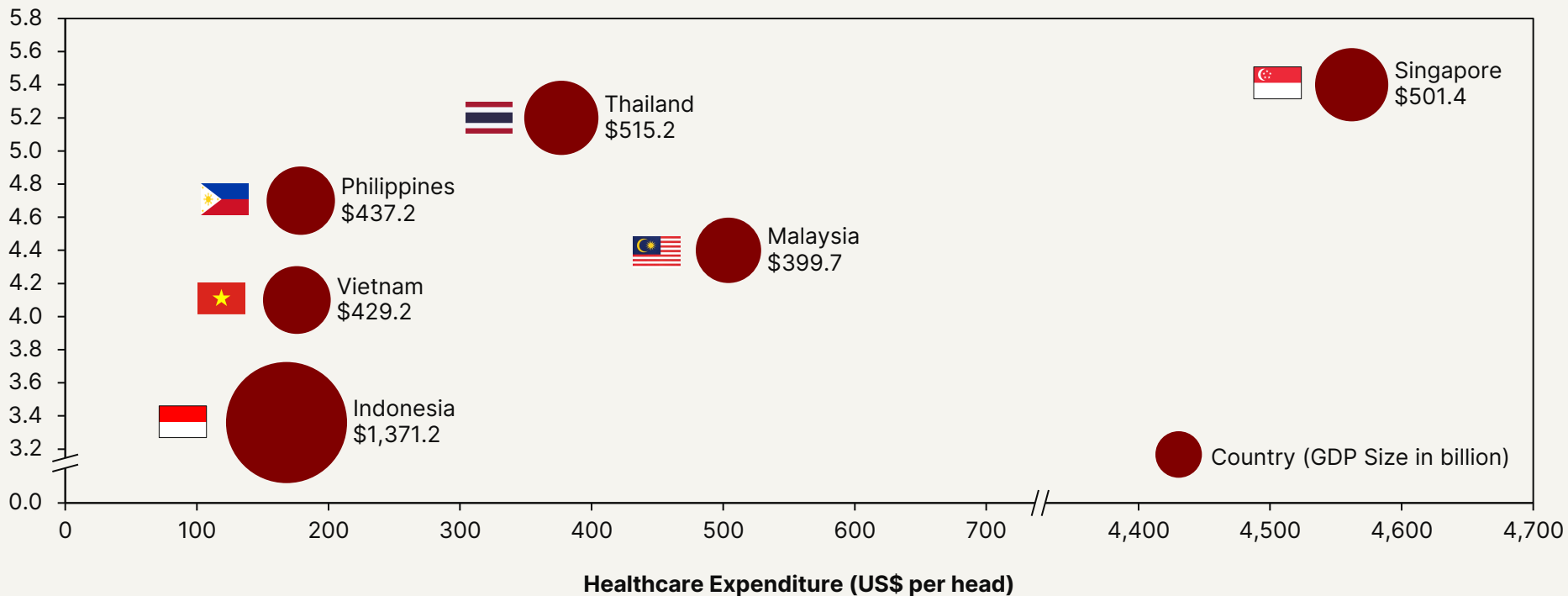


Indonesia ranks the lowest in healthcare expenditure per capita. Other than government commitment, this may be due to affordability challenges and limited access to quality healthcare services and advanced technology in the country.

In contrast, Malaysia stands out with high healthcare expenditure per capita, likely driven by higher purchasing power and substantial investments in healthcare infrastructure and technology.

This bubble chart clearly illustrates that, despite having the largest economy in ASEAN, Indonesia remains behind other countries in the region.

Healthcare Expenditure (% of GDP)



Singapore and Thailand demonstrate effective healthcare financing, evidenced by a high percentage of funding from public and compulsory sources. Singapore with its three-tiered financing model and Thailand with Universal Coverage Scheme (UCS)

